STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING
PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.
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A. INTRODUCTION

The State of Washington's Department of Social and Health Services implemented a Diagnosis Related Groups (DRG) based reimbursement system for payment of inpatient hospital services to Medicaid recipients. This system is used to reimburse for admissions on or after December 15, 1998.

The standards used to determine payment rates take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs. The system includes payment methods to hospitals for sub-acute care, such as skilled nursing, intermediate, and Level II Inpatient Acute Physical Medicine and Rehabilitation (PM&R) care at rates which are lower than those for inpatient acute care. This includes Level II PM&R care provided by skilled nursing facilities acting as Level II PM&R centers.

The reimbursement system employs three methods to determine hospital payment rates: DRG cost-based rates; DRG contract rates; and rates based on hospitals' ratio of cost to charge (RCC). Contract hospitals participating in the federally waivered Medicaid Selective Contracting Program are paid for services based on their contract bid price and/or an RCC method. Hospitals not located in contract areas and hospitals exempt from selective contracting are reimbursed on a cost-based DRG rate and/or an RCC method.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

Non-contract hospitals in selective contracting program areas provide emergency (including maternity) services, and other DRG exempt services such as AIDS related care. These hospitals are reimbursed on a cost-based DRG rate and/or under the RCC method.

Certain hospitals and services are exempt from the DRG payment methods, and are reimbursed under the RCC payment method.

The following plan specifies the methods and standards used to set these payment rates, including: definitions; general reimbursement policies; methods for establishing cost-based DRG rates; methods for establishing RCC payment rates; upper payment limits; and administrative policies on provider appeal procedures, uniform cost reporting requirements, audit requirements, public notification requirements.

B. DEFINITIONS

The terms used in this plan are intended to have their usual meanings unless specifically defined in this section or otherwise in the plan.

1. Accommodation and Ancillary Costs

Accommodation costs: the expense of providing such services as regular room, special care room, dietary and nursing services, medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

Ancillary costs: the expense of providing such services as laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including anesthesia and postoperative recovery rooms). Ancillary services may also include other special items and services.

2. Case-Mix Index (CMI)

Case-mix index means a measure of the costliness of cases treated by a hospital relative to the cost of the average of all Medicaid hospital cases, using DRG weights as a measure of relative cost.

3. DSHS

DSHS means the Department of Social and Health Services. The DSHS is the State of Washington's state Medicaid agency.

4. Diagnosis Related Groups (DRGs)

DRG means the patient classification system originally developed for the federal Medicare program which classifies patients into groups based on the International Classification of Diseases, the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria. The DRGs categorize patients into clinically coherent and homogenous groups with respect to resource use. The Washington State Medicaid program currently uses 590 valid DRGs for its payment system. There are an additional 168 DRGs that are not used and another 51 DRGs with no weights assigned. Of the 51 DRGs with no weights two are used in identifying ungroupable claims under DRG 469 and 470. The All Patient Grouper, Version 12 has a total of 809 DRGs.

5. Emergency Services

Emergency services means services provided for care required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in: placing the recipient's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Inpatient maternity services are treated as emergency services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

6. HCFA

HCFA means the Department of Health and Human Services Health Care Financing Administration. HCFA is the federal agency responsible for administering the Medicaid program.

7. Hospital

Hospital means an entity which is licensed as an acute care hospital in accordance with applicable State laws and regulations, and which is certified under Title XVIII of the federal Social Security Act.

8. Inpatient Services

Inpatient services means all services provided directly or indirectly by the hospital subsequent to admission and prior to discharge, and includes, but is not limited to, the following services: bed and board; medical, nursing, surgical, pharmacy and dietary services; maternity services; psychiatric services; all diagnostic and therapeutic services required by the patient; the technical and/or professional components of certain services; use of hospital facilities, medical social services furnished by the hospital, and such drugs, supplies, appliances and equipment as required by the patient; transportation services subsequent to admission and prior to discharge; and, services provided by the hospital within 24 hours of the recipient's admission as an inpatient.

9. MI/GAU

MI/GAU as used in Paragraph F.2 and F.3 below means a person certified by the Department of Social and Health Services as eligible for, but not limited to, Limited Casualty Program-Medically Indigent (MI) or General Assistance Unemployable (GAU) services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

10. RCC

RCC means a hospital cost to charge ratio calculated on annual HCFA 2552 Medicare Cost Report data provided by the hospital. The RCC, not to exceed 100 percent, is calculated by dividing adjusted operating expense by adjusted patient revenues. The basic payment is established by multiplying the hospital's assigned RCC ratio (not to exceed 100 percent) by the allowed charges for medically necessary services.

11. Operating, Medical Education and Capital Costs

Costs are the Medicare-approved costs as reported on the HCFA 2552 and are divided into three components:

Operating costs include all expenses except capital and medical education incurred in providing accommodation and ancillary services; and,

Medical education costs are the expenses of a formally organized graduate medical education program; and,

Capital-related costs include: net adjusted depreciation expenses, lease and rentals for the use of depreciable assets, the costs for betterment and improvements, cost of minor equipment, insurance expenses on depreciable assets, interest expense and capital-related costs of related organizations that provide services to the hospital. Capital costs due solely to changes in ownership of the provider's capital assets on or after July 18, 1984, shall be deleted from the capital component.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

12. Uninsured Indigent Patient

Means an individual who receives hospital inpatient and/or outpatient services and the cost of delivered services is not met because he/she has no or insufficient health insurance or other resources to cover the cost. The cost of services for uninsured indigent patients is identified through the hospital's charity and bad debt reporting system. Charity care and bad debt, is defined by the Department of Health through its hospital cost reporting regulations WAC 246-453-010, (4) "INDIGENT PERSONS" (Supplement 1 to Attachment 4.19-A, Part I, Pages 1 through 10) and RCW 70.170 "HEALTH DATA AND CHARITY CARE" (Supplement 2 to Attachment 4.19-A, Part I, Pages 1 through 11), means those patients who have exhausted any third-party sources, including Medicare and Medicaid, and whose income is equal to or below 200 percent of the federal poverty standards, adjusted for family size or is otherwise not sufficient to enable them to pay for the care or to pay deductibles or coinsurance amounts required by a third-party payor; (5) "Charity care" means appropriate hospital-based medical services provided to indigent persons, as defined in this section. Services covered by an insurance policy are not considered an uninsured covered service.

13. Cost Limit For DSH Payments

For the purpose of defining cost under the DSH program a ratio of cost to charge (RCC) is calculated on annual HCFA 2552 Medicare Cost data, per B.10. The RCC is applied to total hospital billed charges to arrive at the hospitals total cost.

14. DSH One Percent Medicaid Utilization Rate

All hospitals must meet the one percent Medicaid inpatient utilization in order to qualify for any of the department's disproportionate share programs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

15. DSH Limit

The DSH limit in Section B.15 is applicable for public hospitals. In accordance with the Omnibus Budget Reconciliation Act of 1993, the amounts paid under DSH programs to public hospitals will not exceed 100 percent of cost.

C. GENERAL REIMBURSEMENT POLICIES

The following section describes general policies governing the reimbursement system.

1. DRG Payments

Except where otherwise specified, DRG exempt hospitals, DRG exempt services and special agreements, payments to hospitals for inpatient services are made on a DRG payment basis. The basic payment is established by multiplying the assigned DRG's relative weight for that admission by the hospital's rate as determined under the method described in Section D. Any recipient responsibility (spend-down) or third party liability as identified on the billing invoice or by the Medical Assistance Administration (MAA) is deducted from the basic payment to determine the actual payment for that admission.

2. DRG Relative Weights

The reimbursement system uses Washington State, Medicaid-specific DRG relative weights. To the extent possible, the weights are based on Medical Assistance (Medicaid) claims for the period February 1, 1992 through December 31, 1993, and Version 12 of the Health Information Systems (HIS) DRG All Patient Grouper software.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

The relative weight calculations were based on Washington Medical Assistance claims, Washington State Department of Health's (CHARS) Relative Weights and New York Medicaid weights. Each DRG was statistically tested to assure that there was an adequate sample size to ensure that relative weights met acceptable reliability and validity standards. Using this protocol, 221 DRG relative weights were based on Medical Assistance cases, 213 DRG weights were based on CHARS data, and 156 DRG weights were based on New York relative weights for the total of 590. The relative weights were standardized to an overall case-mix index of 1.0.

3. DRG High-Cost Outlier Payments

High-cost outliers are cases with extraordinarily high costs when compared to other cases in the same DRG. The reimbursement system includes an outlier payment for these cases. To qualify as a DRG high-cost outlier, the allowed charges for the case must exceed a threshold of three times the applicable DRG payment or $28,000, whichever is greater.

Reimbursement for outlier cases other than cases in children's hospitals (Children's Hospital and Medical Center, Mary Bridge Children's Hospital), and psychiatric DRGs is the applicable DRG payment amount plus 75 percent of the hospital's RCC ratio applied to the allowed charges exceeding the outlier threshold. Reimbursement for DRG psychiatric (DRGs 424-432) outliers is at the DRG rate plus 100 percent of the hospital RCC ratio applied to the allowed charges exceeding the outlier threshold. Reimbursement for outlier cases at the state's two children's hospitals is the applicable DRG payment amount plus 85 percent of the hospital's RCC ratio applied to the allowed charges exceeding the outlier threshold.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

4. DRG Low Cost Outlier Payments

Low cost outliers are cases with extraordinarily low costs when compared to other cases in the same DRG. To qualify as a DRG low cost outlier, the allowed charges for the case must be equal to or less than the greater of 10 percent of the applicable DRG payment or $400. Reimbursement for these cases is the case's allowed charges multiplied by the hospital's RCC ratio.

5. DRG Long Stay Day Outlier Payments

Day Outlier payments are included only for long-stay clients, under the age of six, in disproportionate share hospitals and for children under age one in any hospital. (See C.15 Day Outlier payments).

6. RCC payments

Except where otherwise specified, hospitals and services exempt from the DRG payment method are reimbursed under the RCC method. The basic payment is established by multiplying the hospital's assigned RCC ratio (not to exceed 100 percent) by the allowed charges for medically necessary services. Recipient responsibility (spend-down) or third party liability as identified on the billing invoice or by DSHS is deducted from the basic payment to determine the actual payment for that admission.

7. DRG Exempt Hospitals

The following hospitals are exempt from the DRG payment method.

a. Peer Group A Hospitals

Peer Group A hospitals, as defined in Section D.2.